CalPERS Benefit Services Division, P.O. Box 942711, Sacramento, CA 94229-2711
Telecommunications Device for the Deaf - (916) 326-3240 • (800) 352-2238

Disability Retirement Election Application

❑ **Disability Retirement**
❑ **Service Pending Disability Retirement**
❑ **Industrial Disability Retirement**
❑ **Service Pending Industrial Disability Retirement**

Important: Local Safety Members Should Not Complete Sections C and D.

Section A - Member Information

First Name | Middle Initial | Last Name | Social Security Number

Mailing Address | ❑ Male ❑ Female | Date of Birth

City | Home Phone

State | ZIP | Country | Work Phone

Section B - Retirement Information

Retirement Date (Required for Service Pending) | Employer

Position Title (Do Not Abbreviate)

Other Final Compensation Period to Be Used: From / / To / /

Other California Public Retirement Systems: ❑ Yes ❑ No If yes, complete the section below.

Name of System | Date of Retirement

Section C - Workers' Compensation Information

If you filed a Workers' Compensation claim, please provide the following information.

Workers' Compensation Carrier

Name of Adjuster | Telephone Number

Mailing Address | City | State | ZIP

Claim Number(s) | Date of Injury(ies)

First Name | Middle Initial | Last Name | Social Security Number

Section D - Disability Information

Please complete all the questions below. If you need additional space, attach separate sheets. Please be sure to include your name and Social Security number on all sheets.

What is your specific disability; when and how did it occur?

What are your limitations/preclusions due to your injury or illness?

How has your injury or illness affected your ability to perform your job?

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

Other information you would like to provide.

Did a third party cause your injury? ❑ Yes ❑ No

Name of Treating Physician | Medical Record Number

Address of Treating Physician

City | State | ZIP

First Name | Middle Initial | Last Name | Social Security Number

Section E - Option Election

I have reviewed the options listed and elect the following retirement payment option.

❑ **Unmodified Allowance**. I understand this is the highest monthly allowance payable to me, with no benefits payable upon my death (except the Survivor Continuance Benefit, if applicable). There is no return of contributions.

❑ **Option 1** ❑ **Option 2** ❑ **Option 2W** ❑ **Option 3** ❑ **Option 3W**

❑ **Option 4 (Please check one of the following)**

❑ Option 2W & Option 1 Combined ❑ Option 3W & Option 1 Combined

❑ Specific Dollar Amount to Beneficiary $_____.00 ❑ Specific Percentage to Beneficiary _____%

❑ Reduced Allowance for Fixed Period of Time _____% or Dollar Amount, Through ____/____/____

❑ Multiple Lifetime Beneficiaries (complete information below)

Name | Date of Birth ___/___/___ | Social Security Number

Name | Date of Birth ___/___/___ | Social Security Number

Name | Date of Birth ___/___/___ | Social Security Number

Beneficiary Information

Beneficiary's Social Security Number | Name ❑ Male ❑ Female

Date of Birth ___/___/___ | Relationship

Mailing Address | City | State | ZIP

I understand that my election is irrevocable and that by electing Option 2W, 3W, or 4, I forfeit my right to an increase in my allowance based on the conditions described in the Guide to Completing Your CalPERS Disability Retirement Election Application.

First Name | Middle Initial | Last Name | Social Security Number

Section F - Retired Death Benefit

Lump-Sum Retired Death Benefit Beneficiary

Beneficiary's Social Security Number | Name | Relationship

Mailing Address | City | State | ZIP

The person listed above will receive the Lump-Sum Retired Death Benefit which is payable upon my death. I understand that I may change this beneficiary at any time and that any change in my marital status or the birth or adoption of a child automatically revokes this designation.

Section G - Survivor Continuance

Please answer all four questions and complete the information for each section answered "yes".

Are you currently married? ❑ Yes ❑ No

Spouse's Social Security Number | Name | ❑ Male ❑ Female

Date of Birth | Date of Marriage

Do you have any natural or adopted unmarried children under 18? ❑ Yes ❑ No

Child's Social Security Number | Full Name | Date of Birth

Child's Social Security Number | Full Name | Date of Birth

Do you have any unmarried children who were disabled prior to their 18th birthday and are still disabled? ❑ Yes ❑ No

Child's Social Security Number | Full Name | Date of Birth

Child's Social Security Number | Full Name | Date of Birth

Are your parents dependent upon you for one-half of their support? ❑ Yes ❑ No

Parent's Social Security Number | Full Name | Date of Birth

Parent's Social Security Number | Full Name | Date of Birth

First Name | Middle Initial | Last Name | Social Security Number

Section H - Employer Certification (to be completed by employer)

(Certification *required* only for service pending applications.)

_____/____/_____ _____/____/_____

Employee's Last Day on Payroll | Employee's Separation Date

Balance of Unused Sick Leave Days on Employee's Date of Separation _____

Balance of Educational Leave Days on Date of Separation (Section 20963.1) _____

I hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of my knowledge.

_____ ____/____/____

Employer Signature | Date

_____

Printed Name | Employer Phone Number

Section I - Tax Withholding Election (do not complete for Industrial Disability retirement)

Federal Tax Withholding Election (W4P) (Please make one election only.)

❑ Do Not Withhold Federal Income Tax.

❑ Withhold Federal Income Tax in the amount of $ _____.00 (monthly).

❑ Withhold Federal Income Tax Based on the Tax Tables for:

- ❑ A Married Individual With _____ Tax Withholding Exemptions. (Enter 0 or a Number)
- ❑ A Single Individual With _____ Tax Withholding Exemptions. (Enter 0 or a Number)

❑ In addition to the amount withheld based on the Tax Tables, Withhold $ _____.00 (monthly).

State of California Tax Withholding Election (DE4P) (Please make one election only. This is optional for out-of-state residents.)

❑ Do Not Withhold State of California Income Tax.

❑ Withhold State of California Income Tax in the Amount of $ _____.00 (monthly).

❑ Withhold State of California Income Tax Based on the Tax Tables for:

- ❑ A Married Individual With _____ Tax Withholding Exemptions. (Enter 0 or a Number)
- ❑ A Single Individual With _____ Tax Withholding Exemptions. (Enter 0 or a Number)

❑ In Addition to the Amount Withheld Based on Tax Tables, Withhold $ _____.00 (monthly).

❑ Withhold State of California Income Tax in the Amount of 10 Percent of the Federal Income Tax Withholding Amount.

First Name | Middle Initial | Last Name | Social Security Number

Section J - Member Signature & Notary

(When the member is submitting the application and completes Section E, notarization is required.)

I hereby certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand that to request cancellation of this application I must notify CalPERS before the mailing of my first retirement allowance check.

❑ **I am not married.**

Member's Signature | Date

Spouse's Signature | Date

State of | County of

On _____ before me, _____, personally known to me **or**

❑ proven to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Notary Seal

Witness my hand and official seal OR authorized CalPERS representative signature.

Representative's Signature

Section K - Employer Originated Application

(To be completed if the employer is submitting the application.)

Printed Name of Authorized Signature | Title

Employer's Authorized Signature | Date Signed | Employer Phone Number